

DBHS Practice Protocol

Home Care Training to Home Care Client Services for Children¹



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective June 1, 2007**

¹ Formerly known as Practice Improvement Protocol #12 – Therapeutic Foster Care Services for Children

NOTE:

This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.

Title

Home Care Training to Home Care Client (HCTC) Services for Children

Goal/What Do We Want to Achieve Through the Use of the Protocol?

To ensure that the provision of HCTC services for children is consistent with the Arizona Vision and the Arizona 12 Principles. This protocol outlines the clinical considerations related to initial service delivery, active treatment during service delivery, and necessary transition planning for sound utilization of HCTC services.

Target Population(s)

All Title XIX/XXI eligible children for whom HCTC services are being considered and/or being delivered.

Definitions

Child and Family Team - The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues or mosques, agent from other service systems like CPS or DDD etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

Home Care Training to Home Care Client (HCTC): Home Care Training to Home Care Client services are delivered by a Department of Economic Security (DES)-licensed professional foster home to a child residing in the professional foster home. HCTC services assist and support a child in achieving his/her behavioral health service plan goals and objectives. HCTC services include supervision and the provision of covered behavioral health support and rehabilitation services, including personal care, psychosocial rehabilitation, skills training and development, behavioral interventions and transportation to behavioral health appointments and services including counseling and to facilitate participation in treatment and discharge planning. The [Covered Services Guide](#) allows for exceptions to billing limitations, if additional supports are needed for the HCTC provider. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

Adult Clinical Team – A group of individuals working in collaboration who are actively involved in a person's assessment, service planning and service delivery. At a minimum, the team consists of the person, their guardian (if applicable) and a qualified behavioral health representative. The Team may also include members of the enrolled person's family, physical health providers, mental health or social service providers, representatives of other agencies serving the person, professionals representing disciplines related to the person's needs, or other persons identified by the enrolled person. For persons determined to have a serious

mental illness, the clinical team consists of a team leader, a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client's needs.

Background

Home Care Training to Home Care Client services are delivered to children and youth whose behavioral health needs are severe enough that in the absence of such services the child or youth would be at risk of placement into a restrictive residential setting such as a hospital, psychiatric center, correctional facility, residential treatment program² or a therapeutic group home. HCTC was created to offer another treatment alternative in order to promote home-based, community-based services for children and youth with more complex and intensive behavioral health needs. The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is committed to the provision of individualized behavioral health services in the least restrictive and most family-based setting possible. HCTC services offer the opportunity to provide behavioral health services in a family's home.

Procedures

Professional Foster Homes Delivering Home Care Training Services

Training: Professional foster homes delivering HCTC services are initially licensed by DES, Office of Licensing, Certification, and Regulation (OLCR) as professional foster homes or licensed by federally recognized Indian Tribes that attest to Centers for Medicare and Medicaid Services (via Arizona Health Care Cost Containment System) that they meet equivalent requirements. These HCTC service providers must then receive additional training per the [ADHS/DBHS Provider Manual Section 9.1, Training Requirements](#), including completion of the Arizona Home Care Training Curriculum prior to providing services.

Capacity: The placement capacity of a professional foster home must not exceed the licensing capacity established on the license. Furthermore, the placement capacity should be determined based on the behaviors of the children being served and the intensity of the services needed. Special Provisions for a Professional Foster Home (R6-5-5850) recommend that no more than two (2) children be placed in a home at a given time when HCTC services are being delivered. It is further recommended that an increase in capacity beyond two (2) should be preceded by a review of the professional foster parent's motivation for the increase, a demonstration of verified success parenting two (2) children with complex behavioral health needs, a minimum of one (1) year of verified work experience as a professional foster parent, and verified skills and training in the care of children³ with behavioral health needs. The exception to the above guideline is for the placement of sibling groups, but only when it is determined by the licensing agency and the CFT, that the professional foster home has the skills needed to be successful.

Service Expectations: All professional foster homes delivering HCTC services must complete required training per Provider Manual Section 9.1 and abide by placement capacity expectations.

² Foster Family-Based Treatment Association, (2004). Program standards for treatment foster care, (26).

³ Arizona Department of Economic Security (1998). Family Foster Parent Licensing Requirements. Special Provisions for a Professional Foster Home.

Home Care Training Service Delivery

ADHS/DBHS expects that every child is served within the context of a Child and Family Team and that HCTC services are delivered when this recommendation/decision has been made by the CFT. Child and Family Teams, however, should strive to serve children within their current homes (biological, foster, adoptive family, kinship, etc.) whenever possible, by providing in-home support services rather than seeking an out of home placement. The needs of the family and the child's local community, existing family resources and supports, and additional supportive and therapeutic services the family may require to successfully provide for the child at home should be thoroughly assessed and documented on an ongoing basis. HCTC services should not be recommended until a documented attempt has been made to deliver sufficient covered behavioral health services to the child and family in the family-home setting and/or the medical necessity of HCTC services has been determined by the Child and Family Team. In determining the appropriateness of HCTC services, the recommendation for utilization of HCTC should be based on the presence of serious emotional and/or behavioral health needs that interfere with the child's ability to function in the family.

Priority should always be given to keeping the child in his/her local community and school while maintaining supportive social connections. Home Care Training services should be delivered by a professional foster home and in a community that will most likely meet the child's individual needs and reinforce their unique culture and strengths. The loss of family customs, religious practices, familiar language, food or music, etc. causes unnecessary emotional difficulties that lessen the likelihood of a child's success.

Recruitment efforts should be made by the HCTC agency to license and train professional foster homes that are capable of meeting the needs of children needing HCTC services, or have a current connection to a child who is in need of HCTC services and meet the licensing requirements in Article 58 Family Foster Parent Licensing Requirements;

All of the following should be considered and prioritized when selecting a professional foster home who will be delivering Home Care Training services to a child:

- The child's family should be included in all aspects of planning and treatment in accordance with legal requirements.
- Whenever possible, HCTC services should be delivered by an adult already connected to and significant to the child. Family members, neighbors, teachers, or other members of the child's social community should be considered when searching for an HCTC service provider, given they meet the requirements of professional foster home licensing and are willing to complete the necessary training as outlined above. It is important to obtain agreement with the custodial agency regarding how and when to involve family members as potential placement options.
- When siblings require HCTC services, the siblings should be served together unless precluded by safety, Juvenile Court orders, or other overriding clinical issues. If siblings must be placed separately, the service plan should provide opportunities that support, foster and encourage family ties through collaborative efforts between the respective professional foster home delivering HCTC services, kinship or other caregivers by telephone, written and electronic communication, visitation arrangements, and social activities managed by the caregivers.
- HCTC services should be delivered by a professional foster home most willing and able to meet the child's cultural and language needs.

- The child's past experiences with abuse, neglect, family and significant others, or environmental stressors can affect the child's success in treatment. The CFT needs to take into consideration the number, age, and gender of other children living in the Professional Foster family's home, other family members or adults who live in or frequent the Professional Foster family's home, and the likelihood that the makeup of the family will support the strengths and meet the needs of the child.
- Many children thrive in the presence of pets while others are fearful. Some children are aggressive towards vulnerable animals. The presence of pets in the professional foster home should be considered in the context of the safety of the child, the safety of pets living in the home, and the professional foster home's willingness to accommodate the child's needs and desires relative to pets.
- The geographic location of the professional foster home delivering HCTC services should be considered from multiple perspectives. The professional foster home's proximity to the child's current school and family home can affect the child's level of comfort, the accessibility of supportive and anchoring relationships, the reassurance that often accompanies familiarity, and the child's feelings of safety.
- The ability of the professional foster home to implement the service plan in the area in which they live, the proximity to the child's family, and the proximity of both positive and negative peer influences should be carefully assessed.
- The intensity of needs of every child and his/her presenting behavior challenges should be coordinated with the capabilities of the professional foster family's experience.
- The medical needs of the child and the professional foster home's ability to respond to them on an ongoing basis and in crisis should be considered.
- Information available from the professional foster home's OLCR home study may provide additional information to the Child and Family Team about the professional foster home's ability to meet the individual needs of the child.

Emergency Home Care Training Service Placement: Emergency placement into a Professional, Foster Home delivering HCTC services is discouraged as it does not allow the Child and Family Team, including the child and his/her family, to make an informed decision regarding the needs of the child and the strengths of the professional foster home delivering HCTC services. In the event that HCTC service delivery is needed on an emergency basis the Child and Family Team will work with the T/RBHA and the professional foster care licensing agency to expedite the matching process when appropriate and possible.

Crisis/Safety Plans: Before HCTC services are delivered, a crisis/safety plan is developed (or updated) that can be implemented to support and reinforce the child's success in the professional foster home. While every Behavioral Health Service Plan includes a Crisis Plan component, safety issues may only be addressed when high-risk conditions (e.g. sexual acting out or suicide ideation) are present. The crisis/safety plan should be developed by the Child and Family Team and should include planning to address:

- the safety needs of the child and the community
- what should occur if the clinical situation worsens,
- which next steps will be followed,
- who will be called,
- where the child will be taken (i.e. respite, urgent care, etc) and by whom

Ensuring stability: A primary goal of service planning is service stability, predictability, and continuity to avoid a disruption in services. Once a child bonds with a Professional Foster family, moving can be traumatic. Whenever a child must move to another provider, attachment capacity

and mental health status can be compromised. The Child and Family Team should work with the behavioral health representative and the professional foster care licensing agency to attempt to secure any and all behavioral health services to maintain the child's stability and health. This may necessitate securing additional supports for the HCTC family or utilizing the exceptions to billing limitations outlined in the Covered Services Guide.

The following should be considered and discussed prior to delivering HCTC services in an effort to promote stability:

- Respite care should be secured to support the professional foster home delivering HCTC services to provide necessary rest and relief to the professional foster home.
- Behavioral Health Support and Rehabilitation services should be made available as needed for the child and the professional foster home delivering HCTC services.
- If an acute hospital admission, arrest, or other occurrence (e.g. running away from the home) temporarily results in the child's removal from the professional foster home, the Child and Family Team should review the situation and implement appropriate interventions and services to ensure that the child can return to the same professional foster home when clinically appropriate.
- The event of a young person reaching his/her 18th birthday should not, by itself, require an end to needed and beneficial HCTC service delivery.

Ongoing case management and coordination among all involved CFT members (behavioral health, licensing agency, custodial agency, health plan, etc.) should ensure:

- the behavioral health service plan is well developed and fully implemented,
- there is a timely response to the behavioral health needs within the professional foster home, and
- there is access to indicated behavioral health supports.

Children presenting with violent or aggressive behavior, suicidal or homicidal ideation, or with sexual predatory behavior may require additional, specialized behavioral health services to ensure stability.

Permanency Plans: The DES permanency plan, or if the child is not in the custody of the State, an HCTC discharge plan must be included in the child's Service Plan. Returning the child to his or her family, or searching for an alternative permanent home, must remain an ongoing priority for the Child and Family Team and must be coordinated in collaboration with other involved child serving systems (CPS, Probation, Parole, Tribal Social Services and/or Division of Developmental Disabilities). For children and adolescents in CPS custody, it is understood that the Juvenile Court has sole authority to determine a dependent child's legal case plan, and the Child and Family Team must actively participate in the court process and provide information to the Court in a manner (written, in person, etc.) suitable to determine the most appropriate and clinically sound permanency plan. A professional foster home delivering HCTC services should not be considered a permanent placement option for the child.

Service Expectations: The Child and Family Team's recommendation for HCTC services must be based on documentation of the need for the service and in-home supports must be attempted first when clinically appropriate. Attempts must be made to locate a professional foster home delivering HCTC services who is compatible with the needs and the culture of the child and family. A crisis/safety plan must be developed prior to delivery of HCTC services. The DES permanency plan must remain an ongoing focus of the Child and Family Team and must be coordinated in collaboration with other involved child serving systems. A professional foster home delivering HCTC services should not be considered a permanent placement option for the child.

Home Care Training Services Implementation

HCTC services are delivered when there is need for an active and structured treatment program for serious levels of emotional or behavioral challenges. HCTC services should be delivered through an integrated effort both in the home and in the larger community by specially trained, supervised, and supported professional foster homes in collaboration with the Child and Family Team. It is within these natural settings that ongoing assessments are completed, treatment is delivered based on service plan goals, and outcomes are measured. The Professional Foster families delivering HCTC services are the primary agents for therapeutic treatment and the resulting changes in behavior as well as nurturing care givers⁴.

All professional foster homes delivering HCTC services are expected to⁵:

- Abide by all licensing regulations as outlined in Article 58 Family Foster Parent Licensing Requirements;
- Provide basic parenting functions (e.g. food, clothing, shelter, educational support, meet medical needs, and provide transportation, teach daily living skills, social skills, the development of community activities, and support spiritual/religious beliefs), in addition, provide therapeutic interventions (e.g. anger management, crisis de-escalation, psychosocial rehabilitation, and behavioral intervention) that will aid the child in making progress on service plan goals⁶.
- Provide an environment in which family process, interactions, and activities provide opportunities for therapeutic interventions and the development of age appropriate living and self-sufficiency skills as well as the opportunity to live in a family and community based setting;
- Receive ongoing training, supervision, and support, from the Professional Foster Care licensing agency and the behavioral health representative to ensure the professional foster homes delivering Home Care Training service have the ability to understand and to commit to meeting the child's unique needs;
- Participate in the Child and Family Team (CFT), service planning, HCTC discharge planning, Individualized Education Plans (IEPs), and other planning processes, including Juvenile Court hearings and CPS Case Plan Staffings;
- Keep documentation, per expectations of T/RBHA and licensing agency, of the child's behavior and progress regarding specific outcomes as outlined in the child's service plan;

⁴ Bereika, G. M. (ND) Treatment foster care: It's role in the service system. *Position Papers from the Foster Family-Based Treatment Association*.

⁵ Foster Family-Based Treatment Association, (2004). Program standards for treatment foster care, (19-20).

⁶ The examples stated are not meant to be an exhaustive list, additional parenting functions and therapeutic interventions may be required.

- Assist the child in maintaining contact with his/her family and work actively to enhance these relationships, unless contraindicated by the child's service plan or Child Protective Service's case plan;
- Assist in meeting the child's permanency planning, or HCTC discharge planning goals; and
- Advocate for the child in order to achieve goals within the service plan, obtain educational, vocational, medical, and other services needed to implement the plan, and to ensure timely access to therapeutically indicated services and supports.

Service Expectations: All professional foster homes delivering HCTC services must provide basic parenting functions as well as therapeutic interventions, provide a family environment, receive adequate ongoing training and supervision, participate in all aspects of the child's care and treatment, keep documentation, ensure contact is maintained with the child's family if not contraindicated, participate in DES permanency planning or HCTC discharge planning, and advocate on behalf of the child.

Transition

Although the Child and Family Team strives for stability in living arrangements, a transition will occur when:

- HCTC transition plan goals have been met and the child returns to his/her family of origin;
- HCTC transition plan goals have been met and a permanent family has been identified; or
- HCTC services are unsuccessful in meeting the treatment needs of the child.

All planned transitions from the professional foster home delivering HCTC services must be included in the service plan. Coordination between families, agencies, providers and community supports should begin in advance of an anticipated move, and as soon as a change or transition is considered. Transitions should be implemented in a manner that minimizes change and best prepares the child and family members for the future. In addition, all information that can facilitate a successful transition should be shared.

In certain circumstances, when a child achieves their service plan goals and is no longer in need of HCTC services and can therefore transition to a regular foster care setting, the CFT may determine that the child's placement stability is best met by remaining in the same home under a regular foster care placement arranged by the child's custodial agency. When this is the case and the family providing HCTC services desires to provide regular foster care services, the transition planning will be coordinated through the CFT and the professional foster care licensing agency.

The transition plan should include the following whenever possible:

- Face to face meetings, prior to the move, between the professional foster home delivering HCTC services, the child, and the receiving family to advance and nurture successful relationships;
- Opportunities for the child to become comfortable and settled into the new home through graduated visits, overnight stays, etc. as well as the opportunity for the child to begin to personalize his or her new environment;
- A comprehensive exchange of information between families/providers about the child's needs, strengths, values, culture, and medical and emotional needs;

- Opportunities for the child to express opinions and preferences about transition options;
- Opportunities to process, with any needed clinical/therapeutic support, the child's feelings about the transition itself;
- Updates to the crisis/safety plan (including involvement of the new family/provider) in anticipation of the transition;
- Continuation of the Child and Family Team in the child's new environment;
- Support and Rehabilitation Services that will support the child in their new environment; and
- Ongoing contact with supportive and anchoring relationships in the child's current community.

Transitioning to the age of majority: Although reaching the age of majority does not automatically trigger a change in service delivery, young adults may leave professional foster home settings around their 18th birthday. The Child and Family Team has additional responsibilities when planning for these transitions. Transition planning should be consistent with expectations and timelines outlined in the [Transitioning to Adult Services Practice Protocol](#). The Child and Family Team and the professional foster home delivering HCTC services must ensure that all significant domains of a youth's life are considered and reinforced to facilitate a successful transition to adulthood. Consideration of long-term needs should begin by the time the youth reaches 14 years of age.

The Child and Family Team should ensure that:

- The level of independent living skills has been assessed and all available community and professional resources have been utilized to prepare the child/young adult for independent living. This includes issues such as money management, socialization skills, transportation skills (bus routes, driver's licenses, etc.), and/or other areas as needed.
- Age alone should not determine the need to leave a successful professional foster home delivering HCTC services.
- The child/young adult has been educated about AHCCCS enrollment and understands the processes required to maintain eligibility.
- An Adult Clinical Team is in place in order to provide the best opportunity for success.
- Necessary behavioral health services have been delivered and a plan assuring continuity of care has been developed. This includes, when applicable, Serious Mental Illness (SMI) eligibility determinations, assistance with applications for entitlements and assistance programs, and the coordination of transitions with SMI or General Mental Health/Substance Abuse (GMH/SA) providers.
- An appropriately supplied and furnished home exists to which the child/young adult can be transitioned.
- Educational or vocational needs have been identified and plans have been made which include:
 - completion of high school or General Education Degree (GED) or training,
 - post-secondary education, if being pursued,
 - employment readiness, or
 - a job has been secured.
- The child/young adult's feelings about his or her family have been carefully considered, and both the child and the family have been prepared for the choices the child will likely make once the age of majority is reached.
- Financial needs have been defined and considered in the service plan.

Service Expectations: All planned transitions from professional foster homes delivering HCTC services must be included in the service plan and must be implemented in a manner that best prepares the child and family members for the transition. The Child and Family Team and the professional foster home delivering HCTC services must ensure that, for youth reaching the age of majority, all significant domains of the youth's life are considered and reinforced to facilitate a successful transition to adulthood.

Training and Supervision Expectations

This Practice Protocol applies to T/RBHAs and their subcontracted provider agencies that provide direct service delivery to children.

Each T/RBHA shall establish their own process for ensuring all provider agency clinical staff working with children and adolescents (i.e. Behavioral Health Professionals, Behavioral Health Technicians, and Behavioral Health Paraprofessionals) have read and understand the required service expectations of this Protocol. Formal training on this Practice Protocol is not provided by ADHS/DBHS. Each T/RBHA is required to maintain documentation of this training and make this documentation available to ADHS/DBHS upon request.

Whenever the Protocol is updated or revised, T/RBHAs are required to ensure all provider agency clinical staff working with children and adolescents have read and understand the expectations of the revised Protocol. Again, documentation must be maintained and available upon the request of ADHS/DBHS.

Supervision related to the implementation of this Protocol is to be incorporated into other supervision processes the T/RBHA and their subcontracted provider agencies have in place.

All agencies that recruit and license professional foster homes delivering HCTC services to children, must ensure and document that all required training, per Provider Manual Section 9.1 (Training Requirements), has been completed prior to service delivery.

DES-licensed professional foster homes delivering HCTC services to children must also complete annual training requirements as outlined in R6-5-5850, Special Provisions for a professional foster home.

Anticipated Outcomes and How they will be Measured

Anticipated outcomes of using this Practice Protocol include:

- Establishment of highly-trained professional foster homes delivering HCTC services;
- Appropriate delivery of HCTC services for children and adolescents in professional foster homes;
- High-quality treatment services are delivered while a child or adolescent is living in this setting; and
- Appropriate and continuous planning for transition to permanent, stable settings is an ongoing activity.

These outcomes will be measured through the use of one or more of the following:

- Random audits completed by ADHS/DBHS
 - Independent Case Review (chart reviews)

- Child and Family Team Reviews (interviews, chart reviews, team observation)
- Administrative Reviews (chart reviews)
- Monitoring and Oversight audits
- Length of Stay reports in HCTC settings
- Admission and discharge rates for HCTC settings

As with all children and adolescents receiving behavioral health services in Arizona, regardless of the complexity of their needs or the treatment setting, improved functional outcomes are also expected as a result of implementing this Practice Protocol. These include:

- Avoid delinquency
- Achieve success in school
- Become stable and productive adults
- Lives with family
- Increased stability
- Decrease in safety risks

These outcomes will be measured utilizing the Functional Outcomes Measures which are reported (1) upon intake into the behavioral health system, (2) every six months thereafter, and (3) upon discharge from the behavioral health system. ADHS/DBHS may periodically run reports for those children and adolescents noted to be receiving HCTC services to assess functional outcomes prior to and upon completion of treatment in this setting.

How will Fidelity be Monitored?

Fidelity will be monitored through the use of one or more of the following:

- Independent Case Review (chart reviews)
- Child and Family Team Reviews (interviews, chart reviews, team observation)
- Administrative Reviews (chart reviews)
- Monitoring and Oversight audits
- Review of T/RBHA documentation that clinical staff working with children and adolescents have read and understand the expectations of this Protocol

T/RBHAs are encouraged to also establish a process to monitor professional foster homes delivering HCTC services to ensure adherence to the service expectations.

Home Care Training Services for Children Desktop Guide

Service Expectations:

- **Home Care Training Service Providers:** All professional foster homes delivering HCTC services must complete required training per Provider Manual Section 9.1 and abide by placement capacity expectations
- **Providing HCTC Services in a Professional Foster Home:** The Child and Family Team's recommendation for HCTC services must be based on documentation of the need for the service and in-home supports must be attempted first when clinically appropriate. Attempts must be made to locate a professional foster home delivering HCTC services who is compatible with the needs and the culture of the child and family. A crisis/safety plan must be developed prior to delivery of HCTC services. The DES permanency plan must remain an ongoing focus of the Child and Family Team and must be coordinated in collaboration with other involved child serving systems. A professional foster home delivering HCTC services should not be considered a permanent placement option for the child.
- **Treatment:** All professional foster homes delivering HCTC services must provide basic parenting functions as well as therapeutic interventions, provide a family environment, receive adequate ongoing training and supervision, participate in all aspects of the child's care and treatment, keep documentation, ensure contact is maintained with the child's family if not contraindicated, participate in DES permanency planning or HCTC discharge planning, and advocate on behalf of the child.
- **Transition:** All planned transitions from professional foster homes delivering HCTC services must be included in the service plan and must be implemented in a manner that best prepares the child and family members for the transition. The Child and Family Team and the professional foster homes delivering HCTC services must ensure that, for youth reaching the age of majority, all significant domains of the youth's life are considered and reinforced to facilitate a successful transition to adulthood.

❖ Key elements to remember about this best practice:

- HCTC services were created to offer another treatment alternative in order to promote home-based, community-based services for children and youth with more complex and intensive behavioral health needs.
- It is recommended that no more than two (2) children be placed in a professional foster home delivering HCTC services.
- Child and Family Teams should strive to serve children within their homes (biological family, foster, adoptive, kinship, etc.) whenever possible, by providing in-home support services rather than seeking an out of home placement.
- The child's individual needs, strengths, and culture must be taken into account when selecting a professional foster home to deliver HCTC services.
- Emergency delivery of HCTC services is discouraged as it does not allow the Child and Family Team, including the child and his/her family, to make an informed decision regarding the needs of the child and the strengths of the professional foster home delivering HCTC service.
- HCTC service delivery by professional foster homes is based upon service plan goals and measurable outcomes.

❖ Benefits of using this best practice:

- This Protocol is consistent with the Arizona 12 Principles
- The professional foster home delivering HCTC services to children and youth will be carefully selected.
- Transitions will be thoughtfully coordinated and planned.
- Children and youth will experience an increase in stability of service delivery.